

114TH CONGRESS  
1ST SESSION

# H. R. 3244

To amend title XVIII of the Social Security Act to establish a pilot program to improve care for the most costly Medicare fee-for-service beneficiaries through the use of comprehensive and effective care management while reducing costs to the Federal Government for these beneficiaries, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 28, 2015

Mrs. McMORRIS RODGERS (for herself, Mr. LARSON of Connecticut, Mr. REED, and Mr. SCHRADER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to establish a pilot program to improve care for the most costly Medicare fee-for-service beneficiaries through the use of comprehensive and effective care management while reducing costs to the Federal Government for these beneficiaries, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Providing Innovative  
3 Care for Complex Cases Demonstration Act of 2015”.

4 **SEC. 2. PROGRAM TO IMPROVE CARE FOR HIGHEST COST**

5 **MEDICARE FEE-FOR-SERVICE BENEFICIARIES**

7 Title XVIII of the Social Security Act is amended by  
8 inserting after section 1866E (42 U.S.C. 1395cc–5) the  
9 following new section:

10 “PROGRAM TO IMPROVE CARE FOR HIGHEST COST

11 MEDICARE FEE-FOR-SERVICE BENEFICIARIES

12 “SEC. 1866F. (a) ESTABLISHMENT.—The Secretary  
13 shall conduct under this section a pilot program (in this  
14 section referred to as the ‘program’) to demonstrate im-  
15 provements in patient care and cost savings for the high-  
16 est cost Medicare fee-for-service beneficiaries through en-  
17 rollment of such beneficiaries with participating organiza-  
18 tions. Under the program, the Secretary shall, through a  
19 competitive process, enter into a contract with one or two  
20 selected organizations to offer benefits for items and serv-  
21 ices in service areas identified under subsection (b)(1)(A)  
22 to the highest cost Medicare fee-for-service beneficiaries  
23 (identified under subsection (c)(1)) in the service area in-  
24 volved. The program shall be designed in a manner to pro-  
25 vide comprehensive and integrated care management and

1 services through a network of health care providers to  
2 meet the specialized needs of such identified beneficiaries.

3       **“(b) CONDUCT OF PROGRAM.—**

4       **“(1) PERIOD OF OPERATION AND SCOPE.—**

5           **“(A) INITIAL CONDUCT.—**The program  
6 shall initially be conducted over a 3-year period,  
7 beginning not later than 1 year after the date  
8 of the enactment of this section, in at least 4  
9 service areas, each identified by the Secretary  
10 and each including at least 3 contiguous coun-  
11 ties.

12           **“(B) EXPANSION AND EXTENSION.—**The  
13 Secretary may expand the program to addi-  
14 tional service areas and extend its duration if  
15 the Secretary determines, in consultation with  
16 the Chief Actuary of the Centers for Medicare  
17 & Medicaid Services, that such expansion and  
18 extension will result in additional savings to the  
19 Medicare program and will meet the quality  
20 performance standards established under sub-  
21 section (d)(3)(A)(iii).

22           **“(C) RELATION TO PART D.—**

23           **“(i) IN GENERAL.—**The Secretary  
24 shall design and implement the program in  
25 such manner as to preserve the operation

1                   of part D, including payment, noninter-  
2                   ference, and beneficiary protections under  
3                   such part.

4                   “(ii) COORDINATION MECHANISMS.—  
5                   The Secretary shall identify mechanisms  
6                   that may be used, in the case of a highest  
7                   cost Medicare fee-for-service beneficiary  
8                   who is enrolled with a participating organi-  
9                   zation under the program and in a pre-  
10                  scription drug plan offered by a PDP  
11                  sponsor under part D or a qualified retiree  
12                  prescription drug plan offered by a sponsor  
13                  under section 1860D–22, in order to en-  
14                  hance coordination of the individual’s care  
15                  between the organization and the respec-  
16                  tive sponsor.

17                  “(2) NUMBER OF PARTICIPATING ORGANIZA-  
18                  TIONS PER SERVICE AREA.—Under the program the  
19                  Secretary shall enter into a contract with at least  
20                  one selected organization (and no more than 2 se-  
21                  lected organizations) in each service area identified  
22                  and covered under the program.

23                  “(c) IDENTIFICATION AND ENROLLMENT OF HIGH-  
24                  EST COST MEDICARE FEE-FOR-SERVICE BENE-  
25                  FICIARIES.—

1           “(1) IDENTIFICATION.—

2                 “(A) IN GENERAL.—For purposes of the  
3                 program, the Secretary shall develop criteria to  
4                 identify, subject to subparagraph (B), Medicare  
5                 fee-for-service beneficiaries with projected total  
6                 costs under parts A and B in the highest 10th  
7                 percentile of all Medicare fee-for-service bene-  
8                 ficiaries on an ongoing basis. Such criteria shall  
9                 be developed in a manner so as to identify such  
10                beneficiaries using the most recent national  
11                data available for a 2-year period.

12                “(B) REFINEMENT OF ELIGIBILITY CRI-  
13                TERIA.—In identifying highest cost Medicare  
14                fee-for-service beneficiaries under this para-  
15                graph, the Secretary shall develop such criteria  
16                in a manner that eliminates, to the extent prac-  
17                ticable, the identification of individuals who oth-  
18                erwise appear to meet such criteria only be-  
19                cause of a single, isolated high-cost incident,  
20                item, or service.

21                “(2) ELIGIBLE BENEFICIARY INITIAL OUT-  
22                REACH.—The Secretary shall inform the highest cost  
23                Medicare fee-for-service beneficiaries residing in an  
24                area covered by the program of the program and  
25                provide them with information about the program

1 and the process for enrollment and disenrollment  
2 from participation organizations in such area. Such  
3 information shall include information about such or-  
4 ganizations, about rights and protections under the  
5 program, a contact telephone number where bene-  
6 ficiaries can obtain additional information about the  
7 program, and the use of an advance directive (as de-  
8 fined in section 1866(f)(3)) in connection with par-  
9 ticipation in the program.

10                 “(3) AUTO-ENROLLMENT AND DISENROLLMENT  
11                 PROCEDURES.—

12                 “(A) IN GENERAL.—Under the program,  
13                 the highest cost Medicare fee-for-service bene-  
14                 ficiaries residing in a service area covered under  
15                 the program—

16                 “(i) shall be enrolled, in a form and  
17                 manner specified by the Secretary, with a  
18                 participating organization offered under  
19                 the program to such a resident in such  
20                 area; and

21                 “(ii) may change or terminate such  
22                 enrollment in a form and manner so speci-  
23                 fied.

24                 In specifying such form and manner, the Sec-  
25                 retary shall take into account the form and

1 manner in which individuals may change or ter-  
2 minate an enrollment under a Medicare Advan-  
3 tage plan under part C, including permitting  
4 special disenrollment periods described in sec-  
5 tion 1851(e)(4).

6 “(B) DEFAULT ORGANIZATION SELEC-  
7 TION.—In carrying out subparagraph (A), if  
8 there are two participating organizations in a  
9 service area, the Secretary shall identify, to the  
10 extent possible, and enroll the beneficiary in the  
11 participating organization which has providers  
12 in its network from whom the beneficiary has  
13 received services under the Medicare fee-for-  
14 service program in the previous year.

15 “(C) TIMEFRAMES.—In carrying out sub-  
16 paragraph (A), there shall be an initial enroll-  
17 ment period of 12 months, during which a high-  
18 est cost Medicare fee-for-service beneficiary may  
19 also opt out of participation in the program.

20 “(4) EXTENSION OF CERTAIN GUARANTEED  
21 ISSUANCE RIGHTS TO MEDIGAP COVERAGE IN CASE  
22 OF DISENROLLMENT.—Subparagraph (A) of section  
23 1882(s)(3) shall apply to a Medicare beneficiary en-  
24 rolled with a participating organization under this  
25 section who had previous coverage under a medicare

1 supplemental insurance policy and who terminates  
2 enrollment with the participating organization in the  
3 same manner as such section applies to an individual  
4 described in subparagraph (B)(v) of such section  
5 with respect to enrollment with a health plan, re-  
6 gardless of the time period of participation in the  
7 program and without regard to subparagraph (E)(ii)  
8 of such section.

9                 “(5) TREATMENT OF MEDICARE FEE-FOR-SERV-  
10 ICE BENEFITS TO ENROLLEES THROUGH PRO-  
11 GRAM.—The provisions of section 1851(i) shall apply  
12 to individuals enrolled with a participating organiza-  
13 tion under the program in the same manner as they  
14 apply to an individual enrolled in a Medicare Advan-  
15 tage plan under part C.

16                 “(6) RELATION TO PART D, EMPLOYER-BASED  
17 PRESCRIPTION DRUG COVERAGE, AND MEDICARE  
18 SUPPLEMENTAL COVERAGE.—Except as specifically  
19 provided, nothing in this section shall be construed  
20 as intending to impact on benefits or coverage fur-  
21 nished under a prescription drug plan under part D,  
22 under a group health plan (including under a qual-  
23 fied retiree prescription drug plan as defined in sec-  
24 tion 1860D–22(a)(2)), or under a medicare supple-  
25 mental policy.

1       “(d) PARTICIPATING ORGANIZATION REQUIRE-  
2 MENTS.—

3           “(1) IN GENERAL.—For purposes of participating in the program, except as provided in this subsection, a participating organization must meet the same requirements that apply to a Medicare Advantage organization and an MA plan that is not an MA–PD plan under part C, including requirements relating to—

10           “(A) coverage of items and services under parts A and B; and

11           “(B) beneficiary protections under part C.

12           “(2) WAIVER AUTHORITY.—Under the program, the Secretary may waive the requirements of this title and title XI but only to the extent necessary to permit participating organizations—

13           “(A) to provide care management, custodial care, transportation, in-home assistance, and other services that are not otherwise covered under this title;

14           “(B) to structure patient incentives, such as a reduction or elimination of cost-sharing, for services and benefits under parts A and B and the use of in-home technology, to improve beneficiary adherence to treatment protocols

1           and the effectiveness of treatment for enrolled  
2           beneficiaries with chronic clinical conditions;  
3           and

4           “(C) to maintain provider and pharmacy  
5           networks that do not otherwise meet network  
6           adequacy standards.

7           “(3) QUALITY AND REPORTING REQUIRE-  
8           MENTS.—

9           “(A) IN GENERAL.—Under the program,  
10          the Secretary shall—

11           “(i) determine appropriate measures  
12           (including, to the extent feasible, outcome  
13           measures) to assess the quality of care  
14           being provided under the program;

15           “(ii) establish requirements for par-  
16           ticipating organizations to report, in a  
17           form and manner specified by the Sec-  
18           retary, information on such measures;

19           “(iii) establish quality performance  
20           standards on such measures to assess the  
21           quality of care being provided by such or-  
22           ganizations under the program; and

23           “(iv) seek the input of stakeholders  
24           (in a manner similar to that provided for

1                   under section 1848(r)) in determining such  
2                   measures, requirements, and standards.

3                   “(B) TERMINATION OF PARTICIPATION  
4                   FOR FAILURE TO MEET QUALITY PERFORMANCE  
5                   STANDARDS.—The Secretary may terminate  
6                   participation of an organization under the pro-  
7                   gram for failure to meet the quality perform-  
8                   ance standards established under subparagraph  
9                   (A)(iii).

10                  “(C) QUALITY PERFORMANCE STAND-  
11                  ARDS.—In establishing quality performance  
12                  standards under subparagraph (A)(iii) in the  
13                  case of—

14                  “(i) a provider-based organization  
15                  (such as an accountable care organization),  
16                  the Secretary may apply the quality meas-  
17                  urement system used under the Medicare  
18                  shared savings program under section  
19                  1899(b)(3); and

20                  “(ii) an MA organization, the Sec-  
21                  retary may require that only an organiza-  
22                  tion with a rating (under the star quality  
23                  rating system under section 1853(o)(4)) of  
24                  4 stars or higher be permitted to partici-  
25                  pate in the program.

1               “(4) USE OF INTEGRATED MODEL OF CARE.—

2               The Secretary shall develop care management re-  
3               quirements for participating organizations that pro-  
4               vides an integrated care model and that includes the  
5               following elements:

6               “(A) Provision of person-centered, com-  
7               prehensive, and integrated care management  
8               and services.

9               “(B) Provision of services through—

10               “(i) the use of a network of providers  
11               characterized as best-in-class, such as cen-  
12               ters of excellence; and

13               “(ii) the use of an interdisciplinary  
14               management team that includes a nurse  
15               coordinator (or other appropriate health  
16               care professional) assigned to each enrolled  
17               beneficiary and that shares a common  
18               health information technology platform.

19               “(C) An evidence-based model of care with  
20               appropriate networks of providers and special-  
21               ists.

22               “(D) For each beneficiary enrolled with  
23               the organization under the program, the organi-  
24               zation—

1                 “(i) conducts an initial assessment  
2                 and an annual reassessment of the bene-  
3                 ficiary’s physical, psychosocial, and func-  
4                 tional needs, including an evaluation and  
5                 plan with respect to the beneficiary’s  
6                 chronic conditions;

7                 “(ii) provides for regular in-person  
8                 visits to the beneficiary by a care provider  
9                 and provides the beneficiary with access to  
10                 a specialized team, including a hospitalist  
11                 physician; and

12                 “(iii) develops a plan, in consultation  
13                 with the beneficiary as feasible, that identi-  
14                 fies goals and objectives with respect to the  
15                 beneficiary, including measurable outcomes  
16                 as well as specific services and benefits to  
17                 be provided.

18                 “(e) PAYMENTS.—

19                 “(1) IN GENERAL.—For each individual en-  
20                 rolled with a participating organization under the  
21                 program, the Secretary shall make a monthly  
22                 capitated payment to the organization in the same  
23                 manner as such a payment would be made under  
24                 part C for an individual enrolled in an MA-plan

1       (that was not an MA–PD plan) offered by a Medi-  
2       care Advantage organization, except that—

3               “(A) notwithstanding section 1853, the  
4               amount of the payment shall be determined,  
5               subject to subparagraph (B), in an amount  
6               equivalent to 98 percent of the projected cost,  
7               under the Medicare fee-for-service program  
8               under parts A and B for the highest cost Medi-  
9               care fee-for-service beneficiaries; and

10              “(B) the amount of such payment shall be  
11               adjusted, in a manner specified by the Sec-  
12               retary, to take into account differences in costs  
13               among different geographic areas and among  
14               high cost Medicare fee-for-service beneficiaries  
15               (including outlier costs for the most costly such  
16               beneficiaries).

17              “(2) PROJECTION BASED UPON HISTORICAL  
18               DATA.—In applying paragraph (1)(A), the Secretary  
19               shall use historical fee-for-service spending and en-  
20               rollment data for the highest cost Medicare fee-for-  
21               service beneficiaries, trended forward to the first  
22               year of the program, and, for subsequent years of  
23               the program, increased by projected growth in such  
24               spending for such beneficiaries.

1           “(3) RELATIONSHIP TO PAYMENT FOR COV-  
2         ERED PART D DRUGS.—In the case of an individual  
3         who is enrolled with a participating organization  
4         under the program—

5           “(A) if the individual is enrolled with a  
6         prescription drug plan under part D, payment  
7         for covered part D drugs for such individual is  
8         made under such prescription drug plan under  
9         such part and not under the program; and

10          “(B) if the individual is covered under a  
11         qualified retiree prescription drug plan under  
12         section 1860D–22, payment for covered part D  
13         drugs for such individual is made under such  
14         plan and not under the program.

15          “(f) EVALUATION AND REPORT TO CONGRESS.—

16          “(1) EVALUATION.—The Secretary shall con-  
17         duct an independent evaluation of the program.  
18         Such evaluation shall include an analysis of the im-  
19         pact of the program on coordination of care, expend-  
20         itures by participating organizations and plans, the  
21         program’s impact on reducing expenditures under  
22         this title, beneficiary access to services and pro-  
23         viders, the quality of health care services furnished  
24         to beneficiaries, and beneficiary experiences with

1       auto-enrollment and disenrollment under the pro-  
2       gram.

3           “(2) REPORT.—Not later than 2 years after the  
4       date that Medicare beneficiaries are first enrolled  
5       under the program, the Secretary shall submit to  
6       Congress a report on the performance of the pro-  
7       gram. Such report shall include the results of the  
8       evaluation conducted under paragraph (1) and the  
9       program’s impact on reducing expenditures under  
10      this title and on improving the quality of care for  
11      the highest cost Medicare fee-for-service beneficiaries  
12      enrolled under the program.

13       “(g) DEFINITIONS.—In this section:

14           “(1) HIGHEST COST MEDICARE FEE-FOR-SERV-  
15      ICE BENEFICIARY.—The term ‘highest cost Medicare  
16      fee-for-service beneficiary’ means a Medicare fee-for-  
17      service beneficiary who has been identified under  
18      subsection (c).

19           “(2) MEDICARE FEE-FOR-SERVICE BENE-  
20      FICIARY DEFINED.—The term ‘Medicare fee-for-  
21      service beneficiary’ means an individual who—

22                  “(A) is entitled to benefits under part A,  
23       and enrolled under part B, regardless of the  
24       basis for entitlement or eligibility to benefits  
25       under any such part; and

1               “(B) is not enrolled in a Medicare Advan-  
2               tage plan under part C.

3               “(3) PROGRAM.—Unless the context indicates  
4               otherwise, the term ‘program’ means the program  
5               under this section.

6               “(4) PARTICIPATING ORGANIZATION.—The  
7               term ‘participating organization’ means a selected  
8               organization that has entered into a contract to par-  
9               ticipate in the program.

10               “(5) SELECTED ORGANIZATION.—The term ‘se-  
11               lected organization’ means a provider-based organi-  
12               zation (such as an accountable care organization) or  
13               MA organization (as defined for purposes of part C)  
14               that the Secretary determines—

15               “(A) meets the requirements to provide  
16               services to the highest cost Medicare fee-for-  
17               services beneficiaries under the program; and

18               “(B) is accredited by the National Com-  
19               mittee for Quality Assurance or otherwise is  
20               certified as meeting quality standards.”.

○